IFSP TYPE: (CHECK) ☐ Interim ☐ Initial ☐ Annual Review Date: _____

ENROLLMENT INFORMATION

Date Referral Received:

Child's Name: _____ Resident School: _____

Gender: Male ☐ Female ☐ Date of Birth: _____ Birth to 3 Area: _____

Social Security Number: (optional) _____ **Medicaid Eligible:** Yes ☐ No ☐ Race/Ethnicity: _____

Source of Referral: _____

Name of Child's Primary Care Physician: _____ Telephone Number: ( ) _____

PARENTS/SURROGATE PARENTS INFORMATION: (Please indicate specific relationship to child)

Name: _____

Relationship to Child: _____

Telephone Number: Day: ( ) _____

Night: ( ) _____

Best time to call: _____

Mailing address: _____

_____

Town/City: _____

State: _____ Zip Code: _____ County: _____

Primary Language/Mode of Communication: _____

Name: _____

Relationship to Child: _____

Telephone Number: Day: ( ) _____

Night: ( ) _____

Best time to call: _____

Mailing address: _____

_____

Town/City: _____

State: _____ Zip Code: _____ County: _____

Primary Language/Mode of Communication: _____

Directions to child's home:

SERVICE COORDINATION INFORMATION: (Assigned after IFSP is completed)

Name: _____ Telephone: ( ) _____

Agency: _____ Address: _____

_____ Town/City/State/Zip _____

The meeting was conducted in _____
(family's primary mode of communication)

FAMILY SERVICE PLANNING TEAM

IFSP Meeting Participants: The following individuals attended the IFSP meeting and participated in the development of this IFSP.

NAME	TITLE/AGENCY	ADDRESS	TELEPHONE
	PARENT/		
	PARENT/		
	SERVICE COORDINATOR/		

IFSP Input: In addition to IFSP Team Meeting participants, this plan was developed with information provided by the following person(s):

NAME	AGENCY/ROLE	ADDRESS	TELEPHONE

FAMILY CONSIDERATIONS FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

NOTE: THIS SECTION IS OPTIONAL UPON INFORMED, FAMILY CONSENT.

Family declines ☐ _____ **Parent's Initials**

1. PLEASE DESCRIBE WHAT YOU BELIEVE THE STRENGTHS OF YOUR FAMILY ARE IN MEETING YOUR CHILD'S NEEDS.

2. WHAT TYPE OF HELP WOULD YOU WANT FOR YOUR CHILD AND FAMILY IN THE MONTHS OR YEAR AHEAD?

3. BIRTH TO THREE CONNECTIONS MAY BE ABLE TO HELP YOU TO IDENTIFY AND LOCATE A VARIETY OF RESOURCES/INFORMATION TO ADDRESS SOME CONCERNS THAT YOU OR OTHER FAMILY MEMBERS HAVE. PLEASE CHECK (✓) BELOW ANY AREAS YOU WOULD LIKE TO LEARN MORE ABOUT.

FOR YOUR CHILD:

___ getting around
___ communicating
___ learning
___ feeding, nutrition
___ having fun with other children
___ challenging behaviors or emotions
___ equipment or supplies
___ health or dental care
___ pain or discomfort
___ vision or hearing
___ Other:

FOR YOUR FAMILY:

___ meeting other families whose child has similar needs/support group
___ finding or working with doctors or other specialists
___ coordinating your child's medical care
___ finding out more about how different services work or how they could work better for you
___ planning or expectations for the future
___ information about other available resources
___ transportation
___ legal/advocacy advice
___ remodeling/making adaptations to your home
___ parenting skills training
___ child care
___ finding or working with people who can help you in the home/care for your child so that you can have a break
___ housing, clothing, jobs, food, telephone services
___ family training
___ information/group activities for brothers, sisters, friends relatives, others
___ information about the disability or diagnosis
___ help to cover the extra costs of child's special needs
___ help with insurance/SSI/Medicaid
___ recreation
___ Other:

4. WHAT ELSE DO YOU THINK WOULD BE HELPFUL FOR OTHERS TO KNOW ABOUT YOUR CHILD AND FAMILY?

5. ARE THERE OTHER CONCERNS YOU WOULD LIKE TO DISCUSS?

HOW IS MY CHILD DOING? Summary of Child's Present Levels of Performance

To be completed by the IFSP Team, drawing from description of the child, assessments, evaluations and/or observations, for each category.

Statement of child's current health status, including vision, hearing and physical development.

Include a statement about: What the child knows and understands, and the process of learning (Cognition): how the child gives and receives messages (gestures, facial expression, talking) (Communication Skills); social and emotional skills; and physical development, including large and small motor development, vision and hearing; and self help skills.

Abilities, Interests, Motivations, New Skills:	Concerns, Worries, Frustrations, Things to Work On:

Domain	Test or Observation Used	Tester/Observer/Date	Chronological or Adjusted Age	Age level or range	Standard Deviations
KNOWLEDGE/SKILLS					
Cognitive					
Communication – Receptive					
Communication – Expressive					
APPROPRIATE BEHAVIORS TO MEET NEEDS					
Physical Development – Gross					
Physical Development – Fine					
Adaptive Development					
SOCIAL SKILLS					
Social/Emotional					
Vision					
Hearing					

ELIGIBILITY: ☐ NO ☐ YES: Check: ☐ 25% Below Age Range ☐ Six Month Delay ☐ 1.5 Standard Deviation ☐ Medical Diagnosis

☐ Eligibility determination includes the use of Informed Clinical Opinion
☐ No

Prolonged Assistance: ☐ Yes

FAMILY'S DESIRED MEASURABLE RESULTS OR OUTCOMES

CHECK THE AREA BEING ADDRESSED IN THIS OUTCOME: __Knowledge/Skills (Cognitive / Rec Comm & Exp Comm) __Appropriate Behaviors to Meet Needs (Gross Motor & Fine Motor / Adaptive) __Social Skills (Social/Emotional)

WHAT'S HAPPENING NOW? (CURRENT STATUS)

WHAT DO YOU WANT TO WORK TOWARD? (RESULTS OR OUTCOME STATEMENT/ANNUAL GOAL)

Things we'll do to achieve this result or outcome (Activities/Strategies/Short term objectives)	SERVICES TO CONSIDER	RESOURCES/PEOPLE who will teach/learn/do	WHERE? Location

NOTES, COMMENTS/REVIEW INFORMATION:

DEGREE OF PROGRESS: Date Reviewed: _____

Team's Assessment:

1. ☐ Situation Changed; no longer needed.
2. ☐ Implementation begun, outcome partially attained or accomplished.
3. ☐ Outcome completed, accomplished or attained to the family's satisfaction.

Continue Activity #s: _____ Modify Activity #s: _____ Discontinue Activity #s: _____

EARLY INTERVENTION SERVICES

SERVICE	FREQUENCY / INTENSITY-LENGTH	METHOD	LOCATION CODE	RESPONSIBLE AGENCY/PROVIDER	INITIATION Mo/Day/Yr	DURATION Mo/Day/Yr	FINANCIAL RESPONSIBILITY
SERVICE COORDINATION							

EARLY INTERVENTION SERVICE OPTIONS INCLUDE:

***Transportation and related costs include the cost of travel, including mileage or travel by taxi, common carrier, or other means and the related tolls and parking expenses that are necessary to enable a child eligible under this article and the child's family to receive early intervention services. _____Needed by the family _____Not Needed by the family**

A = Assistive Technology
B = Audiological Services
C = Family Training, Counseling, Home Visits
D = Health Services
E = Medical Diagnostic Services
F = Nursing Services
G = Nutrition Services
H = Occupational Therapy
I = Physical Therapy
J = Psychological Services
L = Social Work Services
M = Special Instruction
N = Speech/Language Therapy including Sign & Cued Language
O = Transportation
P = Vision Services

CO-THERAPY: Identify both services that will be provided, i.e. H/N

FREQUENCY: Indicate whether WEEKLY or MONTHLY.

INTENSITY-LENGTH: Time in minutes or hours of one session.

METHOD OF SERVICE DELIVERY: I = Individual, G = Group.

LOCATION CODES:
200 = Home
210 = Program designed for typically developing children
230 = Service Provider Location
240 = Program designed for children with developmental delays or disabilities
250 = Hospital (Inpatient)
260 = Residential Facility
270 = Other setting / please describe:

Natural Environments

Description of natural environments, that are settings that are natural or normal for the child's age peers who have no disability, in which early intervention will be provided. Include justification of the extent, if any, to which the services will not be provided in a natural environment.

OTHER SERVICES			No other services identified at this time ☐
SERVICE	STEPS TO BE TAKEN	FUNDING SOURCE	WHO'S RESPONSIBLE/HELPER?

PARENT/GUARDIAN CONSENT

PARENTAL CONSENT FOR PROVISION OF EARLY INTERVENTION SERVICES

I HAVE HAD MY PARENTAL RIGHTS THOROUGHLY REVIEWED WITH ME, BOTH VERBALLY AND IN WRITING.
I GIVE CONSENT FOR MY CHILD/FAMILY TO RECEIVE THE SERVICE(S) LISTED IN THIS IFSP.

"Consent" means that the parents have been fully informed of all information relevant to the activity for which consent is sought, in the native language, or other mode of communication; the parents understand and agree in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists any records which will be released and to whom; and the granting of consent by the parents is voluntary and may be revoked in writing at any time.

_____	_____	_____	_____
Parent/Surrogate signature	Date	Parent/Surrogate signature	Date

Date IFSP Copy Delivered to Parent/Surrogate(s): _____

Signature of Service Coordinator: _____

TRANSITION PLANNING CHECKLIST	**The IFSP must include steps to ensure a smooth transition for the child and family.**	
Transition Plan Provisions	Describe Activities	Responsible Person(s)
Notify the local school district in written form that the child will shortly reach the age of eligibility for preschool services under part B.	Planned Date of Notification: _____	
With the approval of the parent(s) of the child, convene a conference among the parent(s), local education agency, and appropriate representatives of the local network at least 90 days (and at the discretion of all such parties, not more than 9 months) before the child is eligible for preschool services, to discuss any such services that the child may receive.	Planned Date of Transition Meeting: _____	
With the approval of the parent(s) of the child, make reasonable efforts to convene a conference among the parent(s), appropriate representatives of the local network, and providers of other appropriate services for children who are not eligible for preschool services under part B, to discuss appropriate services that the child may receive.		
Help the parent(s) to identify, evaluate, and apply for community programs and services that meet their interests and needs.		
Identify and implement steps to help the child and parent(s) adjust to new settings and environments.		
Other:		
Other:		

Transition Planning Comments:

IFSP MODIFICATION/REVISION CHECKLIST

DATE OF CURRENT IFSP: _____

DATE OF THIS REVIEW: _____ ___6 Month Review ___Parent Request ___Other:

TARGET DATE FOR NEXT REVIEW: _____

ITEM/PAGE #	MODIFICATIONS/REVISIONS:	SUMMARY COMMENTS:

COMPLETE AND ATTACH TO THE REVISED IFSP PAGES. MARK ON EXISTING PAGES (DO NOT REMOVE)

IFSP MODIFICATION/REVISION

Meeting Participants: The following individuals attended the IFSP review meeting and participated in the development of these revisions.

NAME TITLE	AGENCY/ADDRESS	TELEPHONE
/PARENT		
/PARENT		
/SERVICE COORDINATOR		
/		
/		
/		
/		
/		

IFSP Input: In addition to IFSP Team Meeting participants, this plan was developed with information provided by the following person(s)

PARENTAL CONSENT FOR PROVISION OF EARLY INTERVENTION SERVICES

I HAVE HAD MY PARENTAL RIGHTS THOROUGHLY REVIEWED WITH ME, BOTH VERBALLY AND IN WRITING.
I GIVE CONSENT FOR MY CHILD/FAMILY TO RECEIVE THE SERVICE(S) LISTED IN THIS IFSP.

"Consent" means that the parents have been fully informed of all information relevant to the activity for which consent is sought, in the native language, or other mode of communication; the parents understand and agree in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists any records which will be released and to whom; and the granting of consent by the parents is voluntary and may be revoked in writing at any time.

Parent/Surrogate signature	Date	Parent/Surrogate signature	Date

Date IFSP Copy Delivered to Parent/Surrogate(s): _____

Signature of Service Coordinator: _____

CHILD'S NAME: DATE:

OPTIONAL PAGE

To the extent appropriate, early intervention services must be provided in the types of settings in which all infants and toddlers and their families participate. Section III is designed to help families and early intervention providers successfully integrate services into the child's and family's life. The IFSP team explores all settings and services developed to meet the family's lifestyle and culture and the child's developmental needs.

"ALL ABOUT MY CHILD"

Who Provided Information? _____ Child's Nickname: _____

Things my child likes to do: Put a "+" in front of them.
Things I'd like my child to do: Put an "0" in front of them.
Use this space for additional activities that are not on the list below.

____	hold/play with toys	____	play with sister(s)
____	take a bath/play with water	____	play with brother(s)
____	watch/listen to TV	____	enjoy other children
____	play outside	____	eat out
____	visit relatives/friends	____	go to a playground
____	eat	____	take a walk
____	get and give hugs	____	"rough house"
____	play with Dad	____	ride in the car
____	play with Mom	____	go grocery shopping
____	listen to music	____	take naps
____	go to church/religious activities	____	go to community center

People my child is with: (names, nicknames, ages, amount of time)

in my home... at day care...

who are friends... who are neighbors, relatives...

The following sections should be utilized during the IFSP meeting to identify potential locations for each individual service as identified in the IFSP to meet the Outcomes. IFSP Team members should use the information provided above in selecting the natural setting for each individual service in this IFSP. It is possible that specific services could be delivered in different settings/locations.

Possible locations/programs your child is presently involved in and that should be considered for possible sites for early intervention services:

____	Child's Home	____	Infant/Toddler Play Group
____	Other Family Location	____	Early Intervention Classroom/Center
____	Family Day Care	____	Hospital
____	Community-Based program	____	Clinic/Provider's Office
____	Child Care Program	____	Other: _____
____	Early Head Start	____	Other: _____

What needs to be done to provide services in the setting(s) chosen by the IFSP Team?

Optional Page

CONFIDENTIAL DOCUMENT	INDIVIDUALIZED FAMILY SERVICE PLAN	CONFIDENTIAL DOCUMENT
CHILD'S NAME:	DATE:	ADDENDUM TO PAGE _____